

GENDER DYSPHORIA SUPPLEMENT

DEFINITIONS

- **Gender:** A social construct referring to attitudes, feelings and behaviors associated with a person's biological sex.
- **Gender-Affirmation Surgery:** Surgery to change primary and/or secondary sex characteristics to affirm a person's gender identity
- **Gender Dysphoria:** Distress caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and associated with gender role and/or primary and secondary sex characteristics).
- **Gender Identity:** A person's deeply held knowledge of their own gender, which can include being a man, woman, both, another gender, or no gender.
- **Non-Binary:** Term used to refer to people whose gender identity is not exclusively male or female, including those who identify with a different gender, a combination of genders, or no gender. It may encompass identities such as agender, bigender, genderqueer or gender-fluid.
- **Primary Sex Characteristics:** Any of the body structures directly concerned with reproduction, including the testes, ovaries, and external genitalia.
- **Licensed Mental Health Professional (LMHP):** A mental health physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, certified psychiatric clinical nurse specialist, licensed behavior analyst, or licensed psychiatric/mental health nurse practitioner as defined in 12 VAC 35-105-20. All LMHPs referred to in this policy should be capable of making reasonably sure that the experienced gender dysphoria is not secondary to, or better accounted for, by other diagnoses, similar to the criteria for *qualified mental health professionals* referred to in WPATH-7 guidelines.
- **Gender Dysphoria-Informed Hormone Prescriber:** A prescribing hormone provider competent in the assessment of gender dysphoria who practices in conjunction with a multidisciplinary gender dysphoria care team.
- **Secondary Sex Characteristics:** Any of a number of manifestations, such as development of breasts or beard, muscularity, distribution of fat tissue, and change in pitch of voice, specific to each sex and incipient at puberty but not directly related to reproduction.
- **Sex:** A construct usually assigned at birth based on the appearance of external genitalia. When external genitalia are ambiguous, internal genitalia, chromosomal status, and hormonal sex are considered when assigning sex.
- **Trans male/Transmasculine:** Term used to describe transgender or non-binary people who were assigned female at birth, but identify with masculinity to a greater extent than with femininity. They could be either trans men or nonbinary.
- **Trans female/Transfeminine:** Term used to describe transgender or non-binary people who were assigned male at birth, but identify with femininity to a greater extent than with masculinity. They could be either trans women or nonbinary.

COVERAGE POLICY

A. Medical Services

Medical (hormonal) therapy for gender dysphoria, including puberty suppressing hormone therapy, gender-affirming hormone therapy and associated laboratory services, will be covered as specified below.

1. **Puberty-suppressing and gender-affirming** hormonal therapy for gender dysphoria is considered medically necessary when ALL of the following criteria are met:

- a. The member has been assessed and diagnosed with gender dysphoria according to DSM-V criteria, by one of the following provider types; and
 - i. A licensed mental health provider; or
 - ii. If the member is over the age of 18, a gender dysphoria-informed hormone prescriber, as defined previously
- b. Medication is recommended and prescribed by, or in consultation with, an endocrinologist or other medical provider experienced in gender dysphoria hormone therapy; and
- c. Coexisting behavioral health and medical comorbidities or social problems that may interfere with diagnostic procedures or treatment are being appropriately treated and are not causing symptoms of gender dysphoria; and
- d. Member has experienced puberty development to at least Tanner stage 2 (stage 2 through 4) or has lab values for Luteinizing Hormone (LH), Follicle Stimulating Hormone (FSH), and the endogenous sex hormones consistent with at least Tanner stage 2; and
- e. The member has capacity to make informed treatment decisions and has assented to treatment after discussion of the potential benefits and risks. The process should include parental or legal guardian consent for unemancipated members under the age of 18.

B. Surgical Services

Surgical treatment for gender dysphoria, including transmasculine and transfeminine procedures, will be covered as specified below.

1. Breast/Chest Gender Affirming Surgeries

- a. The surgeries listed below, including but not limited to the billing codes provided, are considered medically necessary when ALL of the criteria listed in subsections B.1.b through B.1.g, are met and documented.
 - i. Transmasculine
 1. Mastectomy (19303) or reduction mammoplasty (19318)
 2. Chest wall contouring (19303, 19350)
 3. Nipple reconstruction (11920-22, 19350)
 - ii. Transfeminine
 1. Augmentation mammoplasty (15771, 15772, 19325) with implantation of breast prostheses (19340, 19342)
 2. Chest wall reconstruction (19324, 19325, 19340, 19342, 19357, 19364, 19380)
 3. Electrolysis (17380) or laser hair removal (17999) as part of presurgical preparation of the transfeminine chest procedures covered above
- b. The member is at least 18 years of age; and
- c. The member has been assessed, and diagnosed with gender dysphoria according to DSM-V criteria, by a licensed mental health professional; and
- d. The aforementioned licensed mental health professional supports the recommended surgical procedure(s) for the member; and
- e. Coexisting behavioral health and medical comorbidities or social problems that may interfere with diagnostic procedures or treatment are being appropriately treated and are not causing symptoms of gender dysphoria; and
- f. For trans female (transfeminine) members, when at least 12 continuous months of gender-affirming hormonal therapy under the supervision of a physician has resulted in inadequate breast development, OR there is any contraindication to, intolerance of, or patient refusal of hormonal therapy; and
- g. The member has capacity to make informed treatment decisions and has consented to the procedure after a discussion of potential benefits and risks.

2. Genital Gender Affirming Surgeries

- a. The surgeries listed below, including but not limited to the billing codes provided, are considered medically necessary when ALL of the criteria listed in subsections B.2.b through B.2.h, are met and documented.
 - i. Transmasculine
 1. Hysterectomy (58150, 58180, 58260, 58262, 58275, 58290, 58291, 58541-44, 58550, 58552-54, 58570-73)
 2. Salpingo-oophorectomy (58720)
 3. Oophorectomy (58661, 58940)
 4. Vulvectomy (56625), Plastic repair of introitus (56800), Perineoplasty (56810)
 5. Vaginectomy (57106, 57107, 57110)
 6. Urethroplasty (53420, 53425, 53430)
 7. Metoidioplasty (56805, 55899)
 8. Phalloplasty (54400-1, 54405, 54408, 54410-11, 54415-54417, 55899), Partial vulvectomy (56620)
 9. Scrotoplasty (55175, 55180)
 10. Placement of testicular prostheses (54660)
 11. Electrolysis (17380) or laser hair removal (17110, 17111) as part of presurgical preparation of genital surgical procedures covered above
 - ii. Transfeminine
 1. Vaginoplasty (57291, 57292, 57335)
 2. Orchiectomy (54520, 54690)
 3. Urethroplasty (53420, 53425, 53430)
 4. Penectomy (54125)
 5. Clitoroplasty (56805)
 6. Labiaplasty (56620, 15773)
 7. Electrolysis (17380) or laser hair removal (17110, 17111) as part of presurgical preparation of genital surgical procedures covered above
- b. The member is at least 18 years of age; and
- c. The member has been independently assessed, and diagnosed with gender dysphoria according to DSM-V criteria, by TWO licensed mental health professionals; and
- d. Each of the TWO aforementioned licensed mental health professionals recommends the specific surgical procedure(s) for the member; and
- e. Coexisting behavioral health and medical comorbidities or social problems that may interfere with diagnostic procedures or treatment are being appropriately treated and are not causing symptoms of gender dysphoria; and
- f. Members have completed at least 12 continuous months of gender-affirming hormonal therapy under the supervision of a physician unless there is any contraindication to, intolerance of, or patient refusal of hormonal therapy; and
- g. Members have completed at least 12 continuous months of full-time living as the gender congruent with their identity unless one of the members' treating medical providers and one licensed mental health professional both determine that this requirement is not safe for the patient; and
- h. The member has capacity to make informed treatment decisions and has consented to the procedure after a discussion of potential benefits and risks.

C. Procedural & Therapeutic Services

Additional procedural & therapeutic treatments for gender dysphoria, including transmasculine and transfeminine services, will be covered as specified below.

1. Facial feminization or masculinization

- a. The procedures listed below, including but not limited to the billing codes provided, are considered medically necessary when ALL of the criteria listed in subsections C.1.b through C.1.f, are met and documented.
 - i. Tracheal shave [reduction thyroid chondroplasty] (31599), Tracheoplasty (31750)
 - ii. Genioplasty (21120-21123, 21208, 21209)
 - iii. Forehead contouring (21137, 21138, 21139)
 - iv. Electrolysis (17380) or laser hair removal (17999) of the face, head and/or neck
 - b. The member is at least 18 years of age; and
 - c. The member has been assessed, and diagnosed with gender dysphoria according to DSM-V criteria, by a licensed mental health professional; and
 - d. The aforementioned licensed mental health professional recommends the specific surgical procedure(s) for the member; and
 - e. Coexisting behavioral health and medical comorbidities or social problems that may interfere with diagnostic procedures or treatment are being appropriately treated and are not causing symptoms of gender dysphoria; and
 - f. The member has capacity to make informed treatment decisions and has consented to the procedure after a discussion of potential benefits and risks.
2. **Behavioral health**
 - a. Members with gender dysphoria are entitled to the full spectrum of behavioral health services available to enrolled members.
 3. **Speech therapy**
 - a. Members with gender dysphoria are entitled to the full spectrum of speech therapy services available to enrolled members.

D. Pharmacologic Agents

DMAS FFS will continue to ensure reasonable access to testosterone, estrogen, progestin, androgen antagonist and GnRH analog agents for members meeting the criteria for Medical Services outlined in Section A above. This includes coverage of a minimum of one age-appropriate long-acting injectable GnRH analog (intramuscular or subcutaneous) requiring administration not more frequently than every 3 months, AND one age-appropriate subcutaneously implantable GnRH analog requiring administration not more frequently than every 6 months, for which no additional criteria, beyond those in Section A, may be imposed for adolescent members under the age of 18. GnRH analog coverage criteria for members over age 18 must recognize individual treatment goals and should include GnRH analog therapy as a treatment option when there is evidence of failure, intolerance, or inappropriateness of first-line oral or topical alternatives to GnRH analog therapy.

E. Non-Covered Services

Non-covered services include any services not otherwise specified above or not covered by DMAS, including but not limited to:

1. **Other cosmetic procedures**
 - a. Abdominoplasty (15830-15839)
 - b. Blepharoplasty (15820-15823)
 - c. Calf implants
 - d. Cheek/malar implants
 - e. Chemical peel (15788-15793)
 - f. Chin/nose implants or prosthesis (21087)
 - g. Collagen injections (11950-11954)
 - h. Dermabrasion (15780-15787)
 - i. Hair transplantation (15775, 15776)
 - j. Lip reduction
 - k. Liposuction (15876-15879)
 - l. Mastopexy (19316)

- m. Neck tightening
 - n. Pectoral implants for chest masculinization
 - o. Removal of redundant skin
 - p. Voice modifications (e.g., laryngoplasty, glottoplasty or shortening of the vocal cords)
 - q. Gluteal augmentation
2. **Reproductive services**
 - a. Procurement, preservation and storage of sperm, cryopreservation of oocytes or fertilized embryos, surrogate parenting, donor eggs, and donor sperm will not be covered.
 3. **Surgical Reversal**
 - a. Surgery restoring anatomy congruent with a member's initial gender after gender affirming surgery will not be covered. Surgical revisions following any of the covered surgical services will be covered when necessary to ameliorate problematic scar formation, excess tissue development, asymmetry, or other surgical complications.

F. Submitting Clinical Documentation

The treating proceduralist must submit evidence that medical necessity criteria for all covered *Surgical Services* and covered *Facial feminization or masculinization* services described above have been met via the Gender Dysphoria Service Authorization Form (DMAS-P264). Authorization requests must be submitted at least 30 days prior to the scheduled date of procedures/services. If approved, claims must be submitted with an F64 ICD-10 diagnosis code. Reference Managed Care Organization (MCO) policies for MCO service authorization forms. Documentation requirements include the following:

1. Documentation from the requisite number of licensed mental health providers, either via letter of support or a copy of the providers' latest treatment note, dated within the last 12 months and including ALL of the following:
 - a. Member's general identifying characteristics; and
 - b. Description of how the provider meets the definition of a licensed mental health provider; and
 - c. Documentation of the diagnosis of gender dysphoria meeting DSM-V Criteria, including ALL of the following:
 - i. Date of onset; and
 - ii. Duration of the licensed mental health professional's relationship with the member; and
 - iii. Results of the member's psychosocial assessment; and
 - iv. Any relevant diagnostic history; and
 - v. The type of evaluation and therapy or counseling undertaken to date; and
 - d. A description of the clinical rationale supporting the recommendation for the covered service; and
 - e. Progress notes documenting that coexisting behavioral health and medical comorbidities or social problems that may interfere with diagnostic procedures or treatment are being appropriately treated and are not causing the member's gender dysphoria; and
2. Documentation from one of the members' treating providers, either via letter of support or a copy of a providers' latest treatment note, dated within the last 12 months and including ALL of the following:
 - a. Confirmation that members have satisfied any requirements around hormone therapy, as outlined above, including ALL of the following:
 - i. The date the member started hormone therapy; and
 - ii. The member's adherence to the prescribed regimen; and
 - iii. The member's clinical response over the course of hormone therapy; or a detailed description of the member's contraindication to, intolerance of, or refusal of hormonal therapy
 - b. Confirmation that members have satisfied any requirements to live full-time as the gender congruent with their identity, as required above, including ALL of the following:
 - i. The date the member started living as the gender congruent with their identity; and

- ii. The member's experience living as the gender congruent with their identity; or the one treating medical provider's and one licensed mental health professional's rationale for why this requirement is not safe for the patient
- 3. Documentation from the treating proceduralist, either via letter of support or a copy of the provider's latest treatment note, dated in the last 12 months and including ALL of the following:
 - a. Description of how the proceduralist meets WPATH-7 competency guidance, including ALL of the following:
 - i. For *Breast/Chest Gender Affirming Surgeries* and *Genital Gender Affirming Surgeries*, training and licensure in an appropriate field (general surgery, gynecology, plastic surgery, urology); and
 - ii. For *Genital Gender Affirming Surgeries*, specialized competence in genital reconstruction; and
 - b. Description of any recommended electrolysis or laser hair removal, including ALL of the following:
 - i. Explanation of the medical necessity of the procedure, be it preoperative or involving the face, head and/or neck; and
 - ii. Licensure of the qualified professional performing any covered electrolysis or laser hair removal; and
 - c. An attestation that the proceduralist has reviewed the member's care with the asserting licensed mental health provider(s) and the health care professional providing hormone therapy, if applicable; and
- 4. Signed informed consent obtained by the proceduralist, including confirmation of the members' understanding and receipt of oral and written information addressing ALL of the following:
 - a. The different procedural techniques available (including referrals to colleague where appropriate) including advantages and disadvantages of each; and
 - b. The risks and complications of the proposed procedure, including the provider's own complication rates; and
 - c. For any *Genital Gender Affirming Surgeries*:
 - i. That the service may/will make the individual permanently incapable of reproducing; and
 - ii. Options for preservation of fertility, including a review of the services not covered by Virginia Medicaid.
- 5. For patients undergoing hysterectomy, completion of the DMAS-3005 Acknowledgement of Receipt of Hysterectomy Information Form.